Women's Health Screening and Referral Program - Care Questionnaire

The Rhode Island Department of Health would like you to fill out this form while you wait. Your answers will help you and your provider identify services you may need and will help us plan new programs for women. Your answers will be confidential. If you have any concerns, please feel free to discuss it with your provider or call the Family Health Information Line at 1-800-942-7434.

Today's date: ____/____/_____ Date of birth: ____/____/_____

1. Are you trying to get pregnant? ❑ Yes ❑ No
2. Are you and your partner using birth control now? ❑ Yes ❑ No
3. What will you do if you are pregnant?
   - ❑ Keep the baby and raise a family with the father
   - ❑ Keep the baby as a single mother
   - ❑ Place the baby for adoption
   - ❑ Other
   - ❑ Don't know
4. Do you have health insurance? ❑ Yes ❑ No
5. If you are pregnant, do you have someone to help you? ❑ Yes ❑ No
6. Do you ALWAYS have heat, hot water, electricity, and access to a phone? ❑ Yes ❑ No
7. Have you skipped meals or eaten less because you do not have enough money for food? ❑ Yes ❑ No
8. Do you have any concerns about nutrition or diet? ❑ Yes ❑ No
9. Have you visited a doctor in the past year? ❑ Yes ❑ No
10. Do you have any medical or health problems? ❑ Yes ❑ No
11. Do you take a multi-vitamin with folic acid every day? ❑ Yes ❑ No
12. Do you have problems getting to the doctor because of transportation, child care, or other reasons? ❑ Yes ❑ No
13. Do you smoke? ❑ Yes ❑ No
    If no, do you spend time with other smokers? ❑ Yes ❑ No
14. Do you drink beer, wine or hard liquor or use marijuana, cocaine, heroin, or other drugs? ❑ Yes ❑ No
15. Do you use condoms every time you and your partner(s) have sexual intercourse? ❑ Yes ❑ No
16. Have you or your partner(s) had Hepatitis, a **positive** HIV test, or AIDS? ❑ Yes ❑ No
17. At home, do you feel physically or verbally threatened or abused? ❑ Yes ❑ No
18. Do you feel depressed or have other mental health problems? ❑ Yes ❑ No
19. Did you ever have a serious complication with a previous pregnancy or birth? ❑ Yes ❑ No
20. Did you ever deliver a premature baby, a sick baby or have a baby die? ❑ Yes ❑ No
21. Has anyone in your family or your partner's family had any birth defects, mental retardation or developmental delay? ❑ Yes ❑ No

FOR OFFICE USE ONLY

Patient Number: _____ Service Site Number: _____

Positive Pregnancy Test ❑
- ❑ Prenatal Care
- ❑ Home Visiting Program
- ❑ Options Counseling
- ❑ Adolescent Self-Sufficiency Program
- ❑ Rite Care

Negative Pregnancy Test ❑
- ❑ Family Planning
- ❑ Teen Prevention Program
- ❑ Preconception Counseling
- ❑ Other
- ❑ No Referral Available

❑ Home Visiting Program (+) ❑ Other (+/-) ❑ No Referral (-)

❑ Home Visiting Program (+) ❑ Community Action Program (+/-)

❑ WIC (+) ❑ Community Action Program (+/-)
❑ Local Food Bank (+/-) ❑ Other (+/-)

❑ WIC (+) ❑ Nutrition Education (-) ❑ Other (-) ❑ No Referral (-) Available

❑ Early Prenatal Care (+) ❑ Medical Provider (-)

❑ Early Prenatal Care (+) ❑ Medical Provider (-)

❑ Multivitamin (+/-) ❑ Folic Acid Education (+/-)

❑ Home Visiting Program (+) ❑ Other (-) ❑ No Referral (-) Available

❑ Tobacco Cessation Program (+/-) ❑ Tobacco Cessation Education (+/-) ❑ No Referral (-) Available

❑ Substance Abuse Education (+/-) ❑ Substance Abuse Assessment (+/-) ❑ No Referral (-) Available

❑ STD/HIV Education (+/-) ❑ HIV/STD Counseling/Testing (+/-)

❑ Early Prenatal Care (+) ❑ Medical Provider (-)

❑ Domestic Violence Hotline (+/-) 1-800-494-8100

❑ Mental Health Provider (+/-) ❑ No Referral (-) Available

❑ Early Prenatal Care (+) ❑ Preconception Counseling (-) ❑ No Referral (-) Available

❑ Early Prenatal Care (+) ❑ Preconception Counseling (-) ❑ No Referral (-) Available

❑ Genetics Counseling (+/-) ❑ No Referral (-) Available

I give permission to release this information to the community referral agencies indicated above.

Please sign your name (voluntary): _____